

April 23, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0846-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor, a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 34-year-old female who was injured at work when she fell from a ladder, injuring her cervical and lumbar spine and tailbone. She went to the ER and was diagnosed with bruises to her lower pelvic area. The neck and upper back pain began approximately four days after the date of injury, ___. She underwent physical therapy. A CT scan of the cervical spine was performed on June 23, 2002, and it was normal. ___ saw ___ on July 3, 2002, who assessed the patient with neck strain and contusion to the lower back. The patient was seen by ___ on July 17, 2002 and was released to return to work. She sought care from ___ on November 20, 2002 and was diagnosed with brachial neuritis, fracture of the coccyx and lumbar sprain/strain. On 1/6/03, a request for a TENS unit rental was sent to and approved for one month by ___ of ___. Documentation reveals that the patient responded to the TENS unit therapy and was able to return to full duty. A request was made to purchase the TENS unit on 2/12/03 and 2/24/03. The request was denied by ___ and a second time by ___ the rationale given was, "The use of this type of device has not been found to have any greater benefit than home exercise or placebo beyond the acute phase of injury."

REQUESTED SERVICE

The purchase of a TENS unit is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds that ___ will most likely need to continue the use of the TENS unit. The care rendered by ___ falls within the parameters set forth in the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters. A TCA Publication, 1994. The reviewer finds that the use and purchase of a TENS unit is medically reasonable and necessary for this patient.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief

Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 23rd day of April 2003.